MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Communicable Disease and Immunization Division
INVESTIGATION FORM FOR FUNGAL DISEASES

____ Blastomycosis ____ Coccidioidomycosis **Identify if Outbreak Related:** _____

___ Histoplasmosis Other_____

CASE IDENTIFYING INFORMATION

Case Name:_____ Age or Birthdate: _____ Sex: ___ Race:_____

Address:_____ Home phone:_____
(Street) (City) (**County**) Work phone:_____

Occupation:_____ Place of Employment:_____
(If infant or student, list school or daycare)

Attending Physician: _____ Address & Phone_____

Patient Hospitalized: **Y or N** Hospital:_____
(Admission date) _____ (Discharge date) _____ (City)_____
Survived: **Yes or No**

DATE OF SYMPTOM ONSET: _____ **DATE RECOVERED:** _____

SYMPTOMS: (Circle all that apply)

Arthralgias	Fever/Chills	Cough	Night Sweats	Rash	Other_____
Chest pain	Weight Loss	Myalgias	Headache	Shortness of breath	

TEST RESULTS

Xray RESULTS: CHEST Xray: ____ OTHER Xray:____ DATE:_____ FINDING:_____

CULTURED: Sputum Blood Ulcer **Date**: _____ Results (Specify source): _____

SKIN TEST? Y or N **Date**: _____ **Results**: _____

SEROLOGY? Y or N **Acute Sera Date**: _____ **Titer**:_____ **Test**: _____

Convalescent Sera Date:_____ **Titer**:_____ **Test**: _____

Name of person interviewed and relationship to case: _____**Date** _____

Person completing form _____ **Health Dept.** _____

CLINICAL DIAGNOSIS ONLY: Y or N **Date of Diagnosis:** _____
(not laboratory confirmed)

Are there any other household members reported to be ill with similar symptoms? **Y or N**
If yes, list names, ages, onset dates: _____

Are there any other people with a similar illness known to the patient? **Y or N**
If yes, list names, ages, onset dates and telephone numbers where they can be reached: _____

_____

Exposure to possible Sources: The following table is designed to determine if there has been any exposure to areas or animal habitats where **fungal** organisms may exist.

Consider exposure occuring up to SIX weeks prior to the first symptoms.

EXPOSURE TO:	YES	NO	UNKNOWN	COMMENTS (INCLUDE LOCATION AND DATE)
Barns (with pigeons)				
Bats				
Bat Droppings				
Beaver Dams				
Birds				
Bird Droppings				
Chicken Coops				
Caves				
Other poultry or droppings				

Describe circumstances surrounding any exposures listed in the YES column above.

_____

_____

History of other LUNG diseases:_____

History of TUBERCULOSIS: _____

Smoking History (cigarettes, cigars, pipe): _____

Out-of-State travel in last SIX weeks? Y or N If Yes, where?_____